bolic inflammation, followed by suppuration and gangrene of the lungs, the spleen (which is always enlarged), the kidneys, the eyes, the brain, and other organs. The characteristic feature of this form is that, unless a complication should be present, which is rarely the case, there is no peritonitis. It is more dangerous than simple peritonitis, and may occur sporadically; but it is more frequently epidemic, although neither so common nor so intense as the third form. It is not unfrequently an indication that the violence of the epidemic is on the decrease. For while pyæmia without peritonitis scarcely ever ends in death before the ninth day, but is generally protracted over two, three, and more weeks, the third form generally proves fatal within the first week after parturition, and in some cases even the very day after delivery, or a few hours after it. This second form was, in the epidemic I have described above, only observed four times.

The third form is entirely different from the second and the first. There is always peritonitis, but no thrombosis of the veins, which are merely filled with thin, discoloured blood. The disease spreads by absorption through the lymphatic vessels and the connective tissue which envelopes them and the blood-vessels, and where yellow coagula, pus and putrid matter, are accumulated. Besides this local creeping of the disease, there is also general infection by absorption of poisonous matter in the blood, either immediately from the womb or from the infected lymph. This form may, therefore, be called puerperal pyæmia with peritonitis, or pyæmia with lymphangitis. It is the most malignant form regarding intensity, rapidity of course, and fatality, and it is also the most frequent in epidemics of puerperal fever. Of thirty-nine fatal cases in the last epidemic, thirty-five belonged to this form. If death ensued very rapidly, there were only general septic appearances in the body; and local changes only became apparent if the disease was of a somewhat longer duration.

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54. *Pathological Anatomy of Puerperal Fever.*—Professor Buhl, of Munich, having examined the bodies of fifty women who died of puerperal fever, states that a constant and characteristic appearance is a pappy, red or dark brown or grayish-black mass lining the inner wall of the uterus, giving forth sometimes a gangrenous and sometimes a putrefactive smell. It is this matter which supplies the poisonous infection of puerperal fever; but as to the cause of the production of the fever differences of opinion prevail; some regarding it as the consequence of the immediate passage of poisonous matter into the wound, while others think that a preliminary poisoning of the blood by miasmata takes place, the corrupted mass being only a secondary result. Anatomically, we may distinguish two forms of puerperal fever—puerperal pyæmia and puerperal peritonitis—forms which may be clinically distinguished, as it is of importance in prognosis that they should be so.

Puerperal pyæmia does not usually prove fatal before the ninth day, and frequently not until after the third week. It is chiefly met with where the disease does not put on an epidemic form, the veins being the channel of infection; coagula, accompanied by suppuration, being found in the veins of the walls of the uterus, in a pampiniform plexus or in a spermatic vein. In no instance did the author ever find both spermatic veins obstructed, and in only one case was the entire vena cava inferior filled with adherent coagula. These coagula and their subsequent caseous metamorphosis are quite sufficient to establish the existence of puerperal pyæmia, the so-called metastatic abscesses being seldom met with. Œdema of the lungs and ecchymosis of the pleura were frequently met with by the author.

The puerperal peritonitis was more frequent, more violent, and more rapidly fatal than the puerperal pyæmia, inasmuch as death sometimes occurred within two days after delivery, and in but few cases was delayed to the third week. Of the 32 cases of this variety only 2 were chronic, proving fatal in the course of six or eight weeks. In all the cases purulent exudation was found, in 18 instances occupying the tubes, and in 14 the subserous tissue of the uterus. The two conditions were found combined in only 4 instances, and a plugged condition of the veins was observed only in 5 instances. Of the 18 instances in which puerperal pyæmia occurred, in only 2 was there pus in the tubes, and in only 1 subserous effusion of pus; so that of 20 cases of tubal suppuration, in 18 peritonitis

was present, and of the 14 cases of subserous suppuration peritonitis occurred in 13. On the other hand, of 23 cases of purulent coagula of the veins in only 5 did peritonitis occur, and in all these there was subserous or tubal suppuration also, and in 16 cases in which these parts exhibited no pus, no peritonitis took place. The disease of the veins thus bore no relation to the occurrence of peritonitis. It results from these facts, that peritonitis may arise either from the immediate passage of the poisonous material from the uterus through the tubes, or from the conveyance of this from the inner wall of the uterus by the lymphatics. The supposition that the pus may have proceeded from the peritoneum into the tubes is negatived by the fact of these having been free of it in fourteen cases; and the pus of the peri-uterine, subserous tissue or of the lymphatic vessels must be regarded rather as a consequence than a cause of the peritonitis, inasmuch as it was absent here in twenty instances. The prognosis is not alike in these two modes of origin of the peritonitis. That induced by pus from the tubes is a much slighter and more simple inflammatory process, met with when there is little or no epidemic extension of the disease; while the peritonitis resulting from lymphatic absorption is a much severer form of disease, preceding or accompanying general infection, and is especially met with in the epidemic form.

In both of the principal forms of puerperal fever, besides the morbid uterine appearances there were found—1. Almost constantly swelling and watery infiltration of the retro-peritoneal, inguinal, and (though seldomer) the mesenteric glands. 2. Osteophytes on the internal surface of the cranium. 3. In several cases, especially in pyæmia and lymphatic absorption, a distension of the cortical substance of the kidney, together with microscopical appearances corresponding to the acute stage of Bright's disease. In only two of fifty individuals was tuberculosis found.—*Med. Times and Gaz.*, Feb. 1, 1862, from *Froriep's Notizen*, 1861. No. 13.

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55. *Coccygodynia.*—This affection, to which attention was drawn by Professor Simpson, a short time since, is said by SCANZONI to be far from rare, for he has seen twenty-four cases of it during the last four years. It has been, he says, frequently mistaken for a symptom of some disease of the genital organs, which often accompanies it; and also for hemorrhoidal pain. Dr. Scanzoni has never observed the disease except in women who have borne children; and in nine cases, the patients distinctly traced the origin of their pain to the date of their confinement. Of nine women, six had only had one child; and in five cases, the pain appeared after instrumental labour.

We may, therefore, consider that the act of child-bearing is the essential, if not the sole cause of this pain; and we can readily understand why this should be the case, when we recollect the injuries to which the coccyx is liable during confinement. The violent forcing of the lower part of the bone backwards, sometimes to the extent of half an inch, and the stretching and tearing of the attached ligaments, are quite enough to excite inflammation and exudation between the bones which form the coccyx. That this really does frequently happen is shown by the researches of Luschka, who pointed out the frequent anchylosis of the bones of the coccyx which takes place. Dislocation of the bone, of the kind here spoken of, must evidently cause pressure upon and injury of the nerves, by the tearing and rupture of the ligaments which naturally protect and sustain them. Hence, we can readily understand why the delivery of the child should be the cause of coccygodynia.

The persistence of the affection is to be ascribed in part to the peculiar relations of the coccyx to the parts around it, and in part to the diseases which so frequently accompany it. When any change in the position or structure of the bone has taken place, every movement of the lower extremities, sudden sitting down or rising up, or even evacuation of hardened feces, must produce a movement of the bone. Affections of the neighbouring organs also aid in keeping up the coccygodynia. Chronic metritis, ulcerations of the os uteri, anteversion and retroversion, very often accompanying coccygodynia. Dr. Scanzoni cannot, indeed, recollect a single case which was not attended by some one of these affections. He has, for example, seen cases in which the coccygodynia immedi-